570

Medicare

Budget function 570 comprises spending for Medicare, the federal health insurance program for elderly and some disabled people. Medicare currently consists of two parts. Hospital Insurance (Part A) pays health care providers for inpatient care that beneficiaries receive at hospitals; it also pays for care at skilled nursing facilities, some home health care, and hospice services. Supplementary Medical Insurance (Part B) pays for physicians' services, outpatient services at hospitals, home health care, and other services.

Medicare will undergo a major expansion of benefits in 2006, when the program to pay for outpatient prescription drugs under a new Part D will begin. In the following several years, Medicare enrollment will expand substantially as significant numbers of baby boomers become eligible because of disability or because they reach age 65.

Total Medicare spending has been growing at an average annual rate of about 8 percent in recent years. The Congressional Budget Office estimates that gross Medicare outlays will total $329 billion in 2005, including discretionary outlays of $4 billion for the program's administrative expenses. Premium income of about $38 billion, paid mostly by participants in Part B, will offset part of that spending.

Federal Spending, Fiscal Years 2000 to 2005 (Billions of dollars)

						Estimate	Average Annual Rate of Growth (Percent)	
	2000	2001	2002	2003	2004	2005	2000-2004	2004-2005
Budget Authority (Discretionary)	3.0	3.3	3.8	3.8	3.9	4.0	6.5	4.3
Outlays								
Discretionary	3.0	3.3	3.2	3.7	4.0	4.0	7.6	-0.3
Mandatory	194.1	214.1	227.7	245.7	265.0	287.2	8.1	8.4
Total	197.1	217.4	230.9	249.4	269.1	291.2	8.1	8.2

570-01—Mandatory

Raise the Eligibility Age for Medicare

Although the normal retirement age (NRA) for Social Security is scheduled to gradually increase until it reaches 67 for people who were born in 1960 or later, the eligibility age for Medicare will remain at 65 (people can qualify for coverage earlier if they are disabled or have end-stage renal disease). Because the two programs affect the same population, some people have argued that the age requirements should be identical.

This option comprises two alternatives for raising the eligibility age for Medicare. Each alternative assumes that the eligibility age will not be increased until 2015, so people who are currently nearing retirement would not be affected. The first alternative would increase the eligibility age by two months every year beginning in 2015 until it reached 67 in 2026, where it would stay indefinitely. Although the increases under that alternative are consistent with increases currently scheduled for the Social Security NRA, the Medicare eligibility age would remain below the Social Security NRA until 2026 (because the NRA increases started sooner). The second alternative would increase the eligibility age by two months every year beginning in 2015 until it reached 70 in 2044, at which point it would stabilize. That alternative is analogous to the option for raising the Social Security NRA (see option 650-05), but it would be phased in more slowly and would not raise the eligibility age above 70.

By 2075, the reduction in net Medicare spending would be about 0.2 percent of gross domestic product under the first alternative and about 0.8 percent of GDP under the second. Spending would fall by less than enrollment if the eligibility age for Medicare rose to 67 or 70, however, for two reasons. First, people who are 65 or 66 are typically the least costly enrollees because they are younger and tend to be in better health than older enrollees. Second, they might be able to postpone some medical care until they became eligible for the program.

The reduced spending for Medicare would be partially offset by higher spending under Medicaid and the Federal Employees Health Benefits program—both of which would pick up part of the health care costs of those beneficiaries whose eligibility for Medicare had been delayed. Spending under the military's TRICARE For Life program would decline, however, because eligibility for that program is limited to people who are enrolled in Medicare.

The primary rationale for this option is to restrain the growth of Medicare spending to ease long-term budgetary pressures. Life expectancy has risen since the Medicare program began in 1965, and the life expectancy of 65-year-olds is expected to continue increasing. Therefore, on average, people will spend a longer time covered by Medicare, which will raise the program's costs. In addition, raising the Medicare eligibility age will reinforce incentives created by increases in the Social Security NRA for people to delay retirement. Disability among the elderly has declined over time, and jobs are generally less physically demanding, suggesting that a larger fraction of the population may be capable of working past age 65. Many who do so could have access to employment-based insurance.

An argument against this option is that many workers retire before age 65. For those early retirees, raising the Medicare eligibility age would lengthen the time they might be at risk of having no health insurance. Furthermore, raising the eligibility age for Medicare would shift costs that are now paid by Medicare to individuals and to employers who continued to offer health insurance to retirees. Those higher costs might lead more employers to reduce or eliminate health benefits for retirees.

RELATED OPTION: 650-05

RELATED CBO PUBLICATIONS: *The Long-Term Budget Outlook*, December 2003; and *Budget Options*, March 2003, Chapter 4

570-02—Mandatory

Set the Benchmark for Private Plans in Medicare Equal to Local Per Capita Fee-for-Service Spending

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1,345	-2,015	-2,355	-2,668	-2,906	-11,289	-28,714

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the Medicare Advantage program to replace Medicare+Choice as the vehicle by which private health plans participate in Medicare. The MMA retained the basic structure of the Medicare+Choice payment system for 2004 and 2005 but modified it to increase the rates offered to those private plans. A new payment system will be implemented in 2006, and the associated new payment rates will be called benchmarks.

Under the Medicare+Choice program, the payment rate offered to private health plans in each U.S. county was the greatest of three amounts: a minimum (floor) rate; a blend of a local (county-level) rate and the national rate; and a minimum increase (usually 2 percent) from the previous year's rate. That mechanism resulted in payment rates that greatly exceeded average per capita spending in Medicare's fee-for-service (FFS) sector in some areas and payment rates that were lower than FFS spending in other areas.

Among other changes, the MMA modified the payment system by raising payment rates that were below the per capita FFS level to that level. However, the MMA did not reduce payment rates in areas where those rates were higher than the FFS level.

This option would set the benchmark in each county equal to local per capita Medicare fee-for-service spending. That change would reduce Medicare spending by about $1.3 billion in 2006 and $11.3 billion over five years. (Those estimates were completed before the final rule for the Medicare Advantage program was issued and are subject to revision based on information in that rule.)

An argument in favor of this option is that the Medicare program should be neutral as to whether beneficiaries decide to enroll in private plans or remain in the fee-for-service sector. The payment system that will be implemented in 2006, like the current payment system, will give an advantage to private plans because they will be able to operate in areas where their costs exceed FFS spending levels and, if their costs are less than the benchmark, provide additional benefits to attract enrollees. Under that system, Medicare will continue to pay more for enrollees in private plans than it would have paid if they had remained in the FFS sector. Setting the benchmark equal to per capita FFS spending in each county would encourage private plans to operate only in areas where they could provide Medicare services at a lower cost than the FFS sector, without encouraging them to operate in areas where they could not.

An argument against this option is that access to private health plans—and to the additional benefits that many of those plans offer—should not be limited to beneficiaries who live in geographic areas where plans can provide Medicare services less expensively than the FFS sector does. According to that view, setting benchmarks higher than per capita FFS spending in many areas is justified because it encourages plans to enter markets that they otherwise would not serve. Another contention is that private plans should not be expected to provide Medicare services in all markets at a cost that is less than per capita FFS spending because Medicare may be able to use its market power to set FFS payment rates at levels below those that are determined through private-market forces. Moreover, below-market payments to health care providers may result in a less-efficient allocation of resources than would be achieved if more beneficiaries were enrolled in private plans that paid providers at rates determined in the market.

RELATED OPTION: 570-03

RELATED CBO PUBLICATION: *CBO's Analysis of Regional Preferred Provider Organizations Under the Medicare Modernization Act*, October 2004

570-03—Mandatory

Remove Medicare's Payments for Indirect Medical Education from the Benchmarks for Private Plans

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-326	-426	-428	-440	-463	-2,083	-5,082

The Medicare program makes two types of payments to teaching hospitals to account for the higher costs they incur relative to other hospitals for treating Medicare patients. First, payments for the direct costs of graduate medical education (GME) are intended to compensate teaching hospitals for Medicare's share of residents' salaries and benefits, teaching costs, and institutional overhead. Second, payments for the indirect costs of GME are designed to account for the fact that teaching hospitals tend to have greater expenses than other hospitals do for a variety of reasons. (For instance, teaching hospitals typically offer more technically sophisticated services and treat patients with more complex conditions than other hospitals do.) Medicare makes direct and indirect GME payments to hospitals for the inpatient stays of all Medicare beneficiaries, including those who are enrolled in private health plans that participate in the Medicare Advantage program.

In the Medicare Advantage program, the payment rate to private health plans in 2004 for each U.S. county was the greatest of four amounts: a minimum (floor) rate; a blend of a local (county-level) rate and the national rate; a minimum increase from the previous year's rate; and the county's per capita fee-for-service (FFS) spending. Payments for indirect GME are included in the estimate of per capita FFS spending even though the Medicare program makes indirect GME payments directly to teaching hospitals for the inpatient stays of Medicare Advantage enrollees. As a result, the Medicare program is paying twice for indirect GME in counties in which the Medicare Advantage rate is equal to per capita FFS spending—first, as an allowance for indirect GME payments in the Medicare Advantage rate, and second, as a payment to teaching hospitals. Those double payments for indirect GME will continue in the future, although the payment system will be modified and the payment rates will be called benchmarks beginning in 2006 (see option 570-02).

This option would remove payments for indirect GME from the benchmarks for private plans, leaving the payment to teaching hospitals as the only compensation for indirect GME. Making that change would reduce Medicare outlays by $326 million in 2006 and by $2.1 billion through 2010.

A rationale for this option is that there is no basis for making double payments for indirect GME for Medicare Advantage enrollees. Doing so results in unnecessary Medicare expenditures and gives private health plans an unfair advantage over the FFS sector.

A potential drawback of this option is that eliminating the double payment for indirect GME would reduce the revenue that private health plans earned from Medicare, which could lead some plans to reduce the generosity of their benefit packages or to withdraw from the program. Plan withdrawals could reduce the number of Medicare beneficiaries with access to private health plans and the additional benefits they provide.

RELATED OPTION: 570-02

570-04—Mandatory

Reduce Medicare's Direct Payments for Medical Education

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-800	-900	-900	-1,000	-1,000	-4,600	-9,800

Medicare pays hospitals for the inpatient stays of its beneficiaries through the prospective payment system. Under that system, hospitals with teaching programs receive additional amounts for costs associated with graduate medical education (GME). One component of the education-related payment is called direct GME, which covers a portion of a hospital's costs for residents' compensation and institutional overhead. Payments are made on the basis of a hospital's 1984 cost per resident (indexed for changes in consumer prices) and Medicare's share of inpatient days. Direct GME payments for physician residents, received by about one-fifth of U.S. hospitals, totaled $2.2 billion in 2004. (Option 570-05 covers Medicare's indirect payments for medical education.)

Under this option, hospitals' direct GME payments would be set at 120 percent of the national average salary paid to residents in 1987 and updated annually for changes in consumer prices. In effect, this option would reduce teaching and overhead payments while continuing to pay residents' compensation. It would also maintain the current practice of reducing payments for residents who have exceeded their initial period of residency (such a resident is treated as one-half of a full-time-equivalent resident).

The savings from this option would total about $800 million in 2006 and $4.6 billion over five years. Unlike the current system in which GME payments vary considerably by hospital, this option would pay each hospital the same amount for the same type of resident. (Although variations in payment per resident have been reduced since 2001, considerable differences remain.)

An argument in favor of this option is that market incentives appear sufficient to entice young people to enter medicine, so a reduction in the federal subsidy for medical education seems warranted. Because hospitals benefit from the services that residents provide, it is reasonable that they should shoulder more of the costs of residents' training. While residents would bear more of the cost of their education if hospitals responded by cutting residents' salaries or benefits, such action could be justified on the grounds that the training residents received would ultimately enable them to earn higher future incomes.

An argument against this option is that if hospitals lowered residents' compensation, the costs of longer residencies—in terms of forgone income from private practice—could deter some residents from obtaining specialty training. As a result, more residents might choose primary care. That outcome might leave some individual residents worse off (although the Council on Graduate Medical Education and other groups argue in favor of a relative increase in the number of primary care practitioners). Another consideration is that reducing the federal subsidy for medical education could lead some hospitals to cut the resources devoted to training, possibly compromising the quality of their education programs.

RELATED OPTIONS: 550-15, 570-05, 570-06, and 570-07

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-05—Mandatory

Reduce Medicare's Payments for the Indirect Costs of Patient Care Related to Hospitals' Teaching Programs

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-2,900	-3,200	-3,500	-3,700	-3,900	-17,200	-40,700

Under Medicare's prospective payment system for inpatient medical services, hospitals with teaching programs receive additional funds for costs related to graduate medical education (GME). One part of the additional payment to teaching hospitals covers the cost of indirect medical education (IME), or those costs attributable to neither residents' compensation nor other direct costs of running a teaching program. Examples of IME expenses are the added demands placed on staff as a result of teaching activities and the greater number of tests and procedures ordered by residents. IME payments also compensate for the higher proportion of severely ill patients treated at teaching hospitals. (Option 570-04 discusses direct GME payments.)

The IME adjustment provides teaching hospitals with about 5.5 percent more in payments for inpatient services for every increase of 0.1 in the ratio of full-time residents to the number of beds. This option would lower the IME adjustment to 2.7 percent—an amount that the Medicare Payment Advisory Commission has estimated would more closely represent indirect costs—saving $2.9 billion in 2006 and $17.2 billion through 2010.

An argument in favor of this option is that it would bring payments into line with actual teaching costs, thus reducing the federal subsidy without unduly affecting teaching activity. It also would remove an incentive for hospitals to have a higher number of residents than is necessary.

Possible drawbacks of this option are that a lower teaching adjustment could prompt teaching programs to train fewer residents or devote less time and resources to beneficial educational activities. Also, because some centers use a portion of the additional payments they receive to fund charitable care, reducing those payments could lead to diminished care for some severely ill patients.

RELATED OPTIONS: 550-15, 570-04, 570-06, and 570-07

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-06—Mandatory

Equalize Medicare's Capital-Related Payments for Teaching and Nonteaching Hospitals

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-400	-500	-500	-500	-500	-2,400	-5,300

Under the prospective payment system for inpatient hospital services, Medicare pays hospitals an amount for each patient who is discharged that is intended to compensate hospitals for capital-related costs such as depreciation, interest, rent, and other expenses related to property. Hospitals with teaching programs receive additional capital-related payments that are made on the basis of "teaching intensity," which is measured as the ratio of residents to the average daily number of hospitalized patients. An increase of 0.1 in that ratio raises a hospital's capital-related payment by 2.8 percent.

This option would eliminate those extra payments to teaching hospitals. Doing so would save the Medicare program about $400 million in 2006 and $2.4 billion over five years.

One argument in favor of this option is that paying teaching hospitals more than nonteaching hospitals for treating otherwise similar patients may promote inefficient practices at teaching centers. In addition, Medicare's payment adjustments for teaching intensity may distort the market for residency training by artificially increasing the value (or decreasing the cost) of residents to hospitals. According to that argument, if residents' training raised the costs of patient care for a hospital, the hospital should bear those costs in order to encourage an efficient amount of training. Finally, although residents would bear more of the cost of education if hospitals responded by cutting their salaries or benefits, their training would still enable them to eventually earn a high income.

A possible drawback of this option is that it could prompt teaching programs to train fewer residents or to devote less time and resources to beneficial educational activities. Also, since some centers use a portion of their additional payments to fund charity care, reducing those payments could lead to diminished care for some seriously ill patients.

RELATED OPTIONS: 550-15, 570-04, 570-05, and 570-07

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-07—Mandatory

Convert Medicare's Payments for Graduate Medical Education into a Block Grant and Slow Their Growth

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-600	-600	-700	-700	-700	-3,300	-7,300

Three types of Medicare payments to teaching hospitals are tied to the size or intensity of a hospital's residency program: direct graduate medical education (GME) payments (see option 570-04); indirect medical education adjustments for operating costs related to inpatient care (see option 570-05); and indirect medical education adjustments for capital expenses (see option 570-06). Moreover, in addition to receiving GME payments for patients who use traditional fee-for-service Medicare, teaching hospitals currently receive payments for participants in Medicare Advantage health plans. Several factors determine the total GME payment a hospital receives, including the number of Medicare patients treated and discharged and numerical factors used annually to update payments. The Congressional Budget Office expects GME payments to grow at an average rate of 2 percent a year between 2006 and 2015 under current law.

This option would replace the current payment system with a consolidated block grant to fund all GME activities at teaching hospitals. Under the present system, a hospital receives GME payments on the basis of formulas set forth in regulations, and Medicare's total GME spending is the resulting sum of what it owes each hospital. This option assumes that the switch to a block-grant program will occur in 2006 and that the amount of the grant will be based on spending in 2004, with future increases tied to changes in the consumer price index for all urban consumers minus 1 percentage point. Compared with projected spending under current law, federal outlays would decline by $600 million in 2006 under this option and by $3.3 billion over five years.

One advantage of establishing a block grant for the various types of GME payments is that it would allow lawmakers to better monitor the level of funding for medical education. In addition, a reduction in the Medicare subsidy would reduce teaching hospitals' incentives to increase the number of residents in order to boost the payments they receive. The reduced subsidy could also help encourage centers with large teaching programs to adopt more-efficient practices.

A potential drawback of this option is that teaching hospitals might decide as a result of the reduced Medicare subsidy to train fewer residents or to devote less time and resources to beneficial educational activities. Also, since some centers use a portion of the education-related payments they receive to fund charity care, reducing those payments could lead to diminished care for some seriously ill patients.

RELATED OPTIONS: 550-15, 570-04, 570-05, and 570-06

RELATED CBO PUBLICATION: *Medicare and Graduate Medical Education*, September 1995

570-08—Mandatory

Convert Medicare's Disproportionate Share Hospital Payments into a Block Grant

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1,200	-1,600	-2,100	-2,500	-3,100	-10,500	-35,500

Hospitals that serve a disproportionately large number of low-income patients can receive higher payment rates under Medicare than other hospitals do. The Medicare disproportionate share hospital (DSH) adjustment was introduced in 1986 to account for what were assumed to be the higher costs of treating Medicare patients in such hospitals. The DSH adjustment has also come to be seen as a way to protect low-income patients' access to care by providing financial support to hospitals that serve a large share of people from low-income populations. Between 1992 and 1997, annual outlays for Medicare DSH payments rose from $2.2 billion to $4.5 billion. Restrictions established by the Balanced Budget Act of 1997 caused those outlays to decline for a few years, but they resumed growing in 2000. In 2003, the Medicare Modernization Act further boosted DSH payments to rural and small urban hospitals by adjusting the payment formulas. As a result, Medicare DSH payments totaled $7.9 billion in 2004.

This option would convert DSH payments into a block grant to the states. In 2006, each state's grant would be 10 percent less than the estimated sum of Medicare DSH payments made to hospitals in that state in 2005. In subsequent years, the block grant would be indexed to the change in the consumer price index for all urban consumers minus 1 percentage point. In return for the lower Medicare DSH payments, states would have flexibility in how they used their DSH funds. Those changes would decrease Medicare outlays by $1.2 billion in 2006 and by $10.5 billion over five years. (The estimated savings include the lower payment updates that plans participating in the Medicare Advantage program would receive.)

An argument in favor of this option is that the added flexibility provided to states under this option could result in DSH funds' being targeted more appropriately and equitably to facilities and providers that serve low-income populations. For example, rather than going solely to hospitals, such funds might also be used to support outpatient clinics that treat low-income patients.

An argument against this option is that the net reduction in federal payments to hospitals, unless made up for by states with their own funds, would result in some hospitals' receiving less public funding than they do now. That drop in funding could reduce the number of low-income patients they served and the quality of care they were able to provide.

RELATED OPTION: 550-08

570-09—Mandatory

Reduce the Update Factor for Hospital Inpatient Operating Costs Under Medicare

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	0	0	-1,200	-2,400	-3,800	-7,400	-55,000

Medicare compensates hospitals for operating costs tied to providing inpatient services to Medicare beneficiaries under the prospective payment system (PPS). Payments are determined on a per-case basis, according to preset rates that vary with a patient's diagnosis and the characteristics of the hospital. Medicare adjusts those payment rates each year using an update factor that is determined in part by the projected rise in the hospital market-basket index (MBI), which reflects increases in hospitals' costs per case or their unit costs.

Under current law, hospitals that submit quality performance data to the Department of Health and Human Services (DHHS) will receive the full MBI update. The data are reported as a checklist of 10 quality measures that govern the treatment of three medical conditions: heart attack, heart failure, and pneumonia. (Types of quality measures include questions such as "Was a beta-blocker prescribed when the patient was discharged?" or "Had the patient received a pneumococcal vaccination?") By contrast, hospitals that do not submit the information will receive the MBI minus 0.4 percentage points. That reduction will apply for the year in which the hospital does not submit the information and will not be taken into account in subsequent years. (The Congressional Budget Office projects that nearly all hospitals will submit the required data and receive the full update.) Beginning in 2008, the update factor will be the full MBI regardless of the submission of quality performance data.

This option would reduce the Medicare PPS update factor to the annual change in the MBI minus 1 percentage point. That rate would take effect in 2008 and continue through at least 2015. Savings from that reduction would total $1.2 billion in 2008 and $55 billion through 2015.

Supporters of this option reason that granting the full MBI update factor will more than compensate hospitals for their average growth in operating costs. To the extent that the MBI is intended to approximate how much providers' costs would rise if the quantity, quality, and mix of inputs they use to provide care remained constant, the MBI would generally overstate cost inflation because of productivity improvements (such as the tendency of providers to adopt cost-saving technological advances in response to the fixed payments established under the PPS).

Critics of this option contend that Medicare's payments for inpatient services should not be reduced without a careful evaluation of the adequacy of payments for other hospital services (such as outpatient care). Since about one-half of all hospitals are expected to have negative overall Medicare profit margins in 2004, further reductions in the update factor could cause considerable hardship for those hospitals.

570-10—Mandatory

Reduce Medicare's Payments for Hospital Inpatient Capital-Related Costs

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-400	-500	-500	-500	-500	-2,400	-5,500

In 1992, Medicare changed its method of paying hospitals for capital expenses associated with providing inpatient services; specifically, it switched from a cost-based reimbursement system to a prospective payment system (PPS). Under the revised system, hospitals receive a predetermined amount for every Medicare patient treated at their facility to cover capital-related costs. (Those costs include depreciation, insurance, interest, taxes, and similar expenses for the maintenance of buildings and the purchase and upkeep of equipment.) The prospective payment system for capital-related costs applies to over 5,000 participating hospitals that are also reimbursed by Medicare for operating costs under the PPS. A hospital's prospective rate is adjusted to reflect its case mix of patients and other characteristics, such as whether the hospital is new, where it is located, and so forth.

Analyses by the Centers for Medicare and Medicaid Services (CMS), which administers the Medicare program, suggest that the prospective rates for capital payments set in 1992 were too high. Those rates were based on 1989 data projected to 1992; but in actuality, capital costs grew more slowly than expected during those years. Moreover, the level of capital costs per case that was used to set rates in 1989 was probably higher than would be optimal in an efficient market because of incentives created by the Medicare payments. Factors such as changes in capital prices, the mix of patients treated at a given hospital, and the "intensity" (technological complexity) of hospital services contributed to the inflated estimates, which the Medicare Payment Advisory Commission and CMS calculated at between 15 percent and 28 percent, with an average of about 22 percent. Consequently, the Balanced Budget Act of 1997 reduced by 17.8 percent the federal rate for capital payments made to hospitals for patient discharges occurring between 1998 and 2002.

This option would further reduce the prospective payment rate for hospitals' capital-related costs by 5 percentage points—bringing the total reduction to about 22 percent from the initial level. That change would lower Medicare outlays by $400 million in 2006 and $2.4 billion over five years.

A rationale for this option is that Medicare's payments for capital costs represent a small share—about 5 percent—of hospitals' total revenues. Most hospitals would probably be able to adjust to the reductions by lowering their capital costs or by partially covering those expenses through other sources of revenue.

An argument against this option is that hospitals in poor financial condition could have difficulty absorbing the reductions. As a result, the quality of the care that they offered could decline, and they might provide fewer services to people without health insurance.

570-11—Mandatory

Change the Payment System for Physicians in Medicare

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	+2,080	+5,440	+9,110	+13,000	+15,730	+45,360	+139,680

Each year, the Centers for Medicare and Medicaid Services sets fees for physicians' services using the "sustainable growth rate" (SGR) mechanism; the fees are then published in the physician fee schedule. The SGR mechanism establishes both yearly and cumulative expenditure targets for Medicare's combined spending for physicians' services and those services furnished "incident to" (in connection with) a physician visit (for instance, diagnostic laboratory services or physician-administered drugs). Those targets are updated to reflect inflation, overall economic growth, the increase in the number of Medicare enrollees in the fee-for-service sector, and any changes in Medicare outlays that stem from new laws and regulations. If cumulative spending exceeds the cumulative target, as it currently does, the SGR mechanism is designed to reduce payment rates each year so that cumulative spending and the cumulative target eventually converge.

By the end of 2002, spending for physicians' services had exceeded the cumulative target by an estimated $17 billion. Thus, in 2003, physicians were scheduled to receive a negative 4.4 percent update, after having seen a drop in fees of 5.4 percent in 2002. The Congress responded to that imminent reduction by allowing the Administration to boost the cumulative target, thereby producing a 1.6 percent increase in payment rates for physicians' services for 2003. If the SGR method had been allowed to operate, it would have reduced payment rates again in 2004. However, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) replaced that scheduled reduction in rates with increases of 1.5 percent in both 2004 and 2005. Under current law, those off-schedule updates will not significantly affect projected total spending over the next 10 years because, after 2005, the SGR method will again be used to restrain payment rates. Thus, payment rates will be reduced under the SGR method in 2006 and 2007 and will be held below the projected rate of inflation through at least 2014.

The Medicare Payment Advisory Commission (MedPAC) recently recommended that the 2005 update to payment rates for physicians' services be set equal to the change in input prices minus an adjustment for increased productivity. The option considered here would permanently change the mechanism used for updating Medicare's physicians' fees to input prices minus a productivity adjustment. The Congressional Budget Office estimates that adopting such updates will increase Medicare spending by about $2.1 billion in 2006 and by about $45 billion over five years. Alternatively, physician fees could be frozen at their 2005 level. That alternative would increase Medicare spending by about $25 billion over five years.

As an argument in support of this option, the American Medical Association contends that the future fee reductions scheduled to occur under the SGR mechanism will jeopardize Medicare beneficiaries' access to physicians' services. (MedPAC has not identified current problems with Medicare beneficiaries' access to physician care but concludes that changing the physician payment system, as detailed in this budget option, will help maintain access.) Another argument in favor of these changes is that it is unfair to single out just one type of provider—in this case, physicians—when imposing global spending restrictions such as those required by the SGR.

An argument against this option is that increasing fees paid to physicians would add to the already substantial long-term costs of the Medicare program and to the broader budgetary pressures posed by the aging of the baby-boom generation. Over the long term, higher spending by Medicare for physicians' services would boost federal spending, requiring cuts elsewhere in the budget, higher taxes, or more federal borrowing. In addition, raising fees would increase both beneficiaries' cost-sharing obligations and the premiums they pay for Part B of Medicare (which covers physicians' services and outpatient hospital care).

RELATED CBO PUBLICATION: *Medicare's Physician Fee Schedule* (testimony by Douglas Holtz-Eakin, Director, before the Subcommittee on Health of the House Committee on Energy and Commerce), May 5, 2004

570-12—Mandatory

Eliminate the "Doughnut Hole" in Medicare's Drug Benefit Design

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	0	+16,560	+28,950	+33,600	+39,180	+118,290	+426,560

The standard drug benefit under Medicare Part D will have an annual deductible, an initial range of coverage in which beneficiaries will pay 25 percent of their covered drug costs, and a catastrophic threshold above which beneficiaries will pay about 5 percent of their covered drug costs. In the gap between the end of the initial coverage range and the catastrophic threshold, beneficiaries will generally be liable for all of their drug costs. In 2006, that gap—commonly called the "doughnut hole"—will run from $2,250 in drug spending up to $5,100 for enrollees with no supplemental drug coverage. (At that point, Medicare will have covered $1,500 in drug costs for such enrollees, and they will have incurred $3,600 in out-of-pocket drug costs, which is the catastrophic threshold for 2006.)

The gap is effectively larger for enrollees with private supplemental drug coverage because of the drug benefit's "true out-of-pocket" provision, which specifies that costs covered by such supplemental policies do not count toward reaching the catastrophic threshold. Moreover, the gap will grow in dollar terms over time because the benefit's parameters are indexed to average drug costs for Medicare enrollees. Many enrollees with low income and few assets will receive additional federal subsidies to cover most of their drug costs in the doughnut hole, but the Congressional Budget Office estimates that roughly one-third of Part D enrollees will have drug spending that exceeds the standard benefit's initial coverage range in any given year.

This option would completely eliminate the doughnut hole in the standard benefit, starting in 2007, by extending the benefit's initial 25 percent coinsurance rate up to the point at which the catastrophic threshold is reached. As a result, enrollees in 2007 would face 25 percent coinsurance for all drug costs between the deductible (which is now projected to be $285) and $15,545—at which point they would have incurred $4,100 in out-of-pocket drug costs and would reach the currently projected catastrophic threshold for that year. (Because the true out-of-pocket provision would continue to apply, beneficiaries with private supplemental drug coverage would still have to incur higher total drug costs before reaching the catastrophic threshold.)

In CBO's estimation, this option would increase federal outlays by $16.6 billion in 2007 and by $118.3 billion through 2010. That estimate assumes that beneficiaries' premiums would continue to cover 25.5 percent of the costs of providing the basic benefit. Because those costs would increase, CBO estimates that under the option, beneficiaries' average monthly premiums will rise to $57 in 2007 and to $125 in 2015. By contrast, CBO projects that under current law, beneficiaries' monthly premiums will average $38 in 2007 and $72 in 2015. CBO's cost estimate also reflects the fact that an increase in the cost of providing the basic drug benefit to all enrollees will be partially offset by reduced costs for providing the additional drug subsidies for low-income enrollees to cover the smaller cost-sharing liabilities that remain.

Proponents of this option argue that it will reduce cost-sharing burdens on the large number of beneficiaries who are projected to exceed the current benefit's initial coverage limit. Overall, CBO estimates, the average liability per enrollee will fall by about 30 percent (from $1,540 to $1,070) in 2007 under this option. Providing this additional coverage would also reduce the share of total spending that exceeds the catastrophic threshold, so it would lessen the penalty for having supplemental coverage that stems from tying catastrophic coverage to true out-of-pocket costs. (The estimates presented here assume that the subsidy payments from Medicare for employers' drug plans are increased commensurately—so that the average subsidies that employers received in that system would be comparable to the net Medicare subsidies that would be generated if those retirees enrolled in Part D and their former employers wrapped their drug coverage around the basic Medicare benefit.)

One argument against this option is that a substantial portion of the additional federal costs would go to displace spending that would probably have been covered by third parties, such as employers. Also, beneficiaries might object to the fact that the increased premiums would delay their break-even point—that is, the point at which the benefits they receive exceed their premium payments.

(CBO did not assume a reduction in enrollment as a result.) Alternatively, the insurance design of the standard Part D benefit could be improved at a lower federal cost by first increasing the deductible and then raising the coinsurance rate before extending that coverage across the doughnut hole.

RELATED CBO PUBLICATION: *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004

570-13—Mandatory

Increase Medicare's Premium for Supplementary Medical Insurance to 30 Percent of Benefit Costs

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-4,650	-6,440	-6,890	-7,450	-8,070	-33,500	-84,770

Medicare provides health insurance coverage for physicians' services and hospital outpatient services through its Supplementary Medical Insurance (SMI) program, or Medicare Part B. Monthly premiums paid by enrollees partially fund SMI benefits; general federal revenues fund the remainder. Initially, the SMI premium was supposed to cover 50 percent of program costs. But that share declined between 1975 and 1983, eventually reaching less than 25 percent. The drop occurred because the per capita cost of the SMI program rose faster than the Social Security cost-of-living adjustment (COLA), and by law, the annual percentage increase in the premium during that period could not exceed the COLA. The Balanced Budget Act of 1997 permanently set the SMI premiums to cover 25 percent of program costs.

This option would set the SMI premium equal to 30 percent of the cost of Part B benefits, beginning in 2006. Such an increase would save $4.7 billion in 2006 and $33.5 billion over five years and would raise the 2006 premium for enrollees to $95.70 per month instead of $79.80. The estimated savings assume a continuation of the current hold-harmless provisions, which ensure that no Medicare enrollee's monthly net Social Security benefit will fall because the dollar amount of the Social Security COLA is smaller than the dollar increase in the SMI premium. (SMI premiums are deducted from Social Security checks for most enrollees.) The hold-harmless provisions would apply to more enrollees in 2006 because of the initial increase in premiums from 25 percent to 30 percent of program costs.

A main rationale in favor of this option is that it would reduce Medicare's costs amid the broader budgetary pressures posed in part by the aging of the baby-boom generation. Even so, the public subsidy to Medicare's Part B beneficiaries would remain at a high level of 70 percent. Moreover, the option might not affect enrollees with income below 120 percent of the federal poverty line and few assets because they are eligible to have Medicaid pay their Medicare premiums.

An argument against this option is that low-income enrollees who are not eligible for Medicaid could find the higher premiums burdensome. Some might feel compelled to drop SMI coverage altogether or to seek sources of free or reduced-cost care, which could increase demands on local governments. In addition, because states would have to pay part of the higher premium costs for those Medicare enrollees who also receive Medicaid benefits, state expenditures would probably rise.

RELATED CBO PUBLICATIONS: *The Long-Term Budget Outlook*, December 2003; and *Budget Options*, March 2003

570-14—Mandatory

Apply a "Hold-Harmless" Provision to Increases in Medicare's Part D Premium

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	0	+10	+30	+40	+70	+150	+870

Many people enrolled in Medicare Part B (Supplementary Medical Insurance, or SMI) have their premium payments automatically deducted from their Social Security benefit checks. The Medicare Part B premium is set to cover about 25 percent of program costs. However, each year, Social Security payments are subject to a cost-of-living adjustment, or COLA. Under current law, the dollar amount of any increase in the Part B premium is limited by the dollar amount of the COLA for Social Security benefits. Under this "hold-harmless" provision, if the calculated premium increase is greater than the dollar increase in the Social Security benefit, the premium is reduced to the amount needed to ensure that there is no reduction in the dollar amount of the net Social Security payment.

This option would apply a similar hold-harmless provision to the combined premium increases for Medicare Part B and Part D (Medicare's new prescription drug benefit), beginning in 2007. (The option would not affect the initial reduction in the net Social Security benefit that will occur when enrollees first sign up for Part D in 2006.) Because Part D premiums will vary across beneficiaries (depending on the particular plan chosen), the hold-harmless calculations described here are based on the average premium for Part D plans. In other words, the average beneficiary's net Social Security payment could not fall from year to year. If beneficiaries were enrolled in a plan with a sufficiently higher premium increase than that of the average Part D plan, however, they could see reductions in their net Social Security payment.

Expanding the current hold-harmless provision to include the Part D premium would increase Medicare spending by $10 million in 2007 and by $150 million between 2006 and 2010. The number of Medicare beneficiaries subject to both the current and proposed hold-harmless provisions would vary considerably over time, primarily because of significant year-to-year fluctuations in the rates of increase of the Part B and Part D premiums.

A rationale for this option is that it would limit the extent to which the rising cost of prescription drugs reduced the amount of income available to the elderly for spending on other goods and services. It would especially protect the net Social Security benefit of beneficiaries with relatively low lifetime wages (and thus low Social Security benefits) because the dollar amounts of their COLAs would be relatively small.

An argument against this option is that, by insulating beneficiaries from the full impact of sharing in increased premiums for the drug benefit, the policy might reduce pressures to curb growth in Medicare drug spending.

570-15—Mandatory

Restructure Medicare's Cost-Sharing Requirements

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-4,750	-6,790	-6,950	-7,530	-8,300	-34,320	-87,460

In the fee-for-service Medicare program—consisting of Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance)—beneficiaries' cost sharing varies significantly depending on the type of service provided. For example, enrollees who are hospitalized in 2005 must pay a Part A deductible of $912 for each "spell" of illness they incur and are subject to daily copayments for extended hospital stays or skilled nursing care. Meanwhile, the 2005 deductible for outpatient services covered under Medicare Part B is $110. Beyond that deductible, beneficiaries generally pay 20 percent of allowable costs for most Part B services, but cost sharing can be significantly higher for outpatient hospital care. At the same time, certain Medicare services, such as home health visits and laboratory tests, require no cost sharing. As a result of those variations, beneficiaries are not given consistent incentives to weigh relative costs when choosing among treatment options. Moreover, if Medicare patients incur extremely high medical costs, they can face significant cost-sharing expenses, because the program does not cap those expenses.

This option would replace the current complicated mix of cost-sharing provisions with a single combined deductible covering all services in Parts A and B of Medicare, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses), and an annual cap on each beneficiary's total cost-sharing liabilities. Specifically, the combined deductible would be $500 in 2006, and the cap on total cost sharing would be $4,500; in later years, those amounts would grow at the same rate as per capita Medicare costs.

If this option took effect on January 1, 2006, federal outlays would be reduced by $4.7 billion in that year and by $34.3 billion over five years. Those estimates assume that the new Medicare cost-sharing rules will be mandatory for all enrollees (that is, beneficiaries will not be allowed to choose between the new cost-sharing provisions and current-law requirements).

One argument in favor of this option is that it would provide greater protection against catastrophic costs while reducing Medicare's coverage of more predictable expenses. Capping beneficiaries' out-of-pocket expenses would especially help people who develop serious illnesses, require extended care, or undergo repeated hospitalizations but lack supplemental coverage for their cost sharing. This option would also increase incentives for enrollees to use medical services prudently. By design, deductibles and coinsurance rates are mechanisms for exposing beneficiaries to some of the financial consequences of their health care treatments, aimed at ensuring that the benefits of those treatments exceed their costs. While this option's combined deductible would be lower than the Part A deductible, the vast majority of Medicare enrollees are not hospitalized in a given year; thus, most people without supplemental coverage would face the full cost for a larger proportion of the Part B services that they used. The uniform coinsurance rate across services would also encourage enrollees to compare the costs of different treatment options in a more consistent way. In addition, the resulting reductions in costs for Medicare's Part B program would translate into lower premiums for all enrollees.

An argument against this option is that it would increase cost-sharing liabilities for most Medicare enrollees. Specifically, those liabilities would increase modestly in 2006 for about 79 percent of enrollees (by about $650 on average) and would stay the same for another 14 percent. (For the remaining 7 percent of enrollees, cost-sharing liabilities would fall by an average of about $4,950.) Beneficiaries who are hospitalized only once in a year would generally face higher costs because of the coinsurance that would apply to that care; however, most Medicare beneficiaries would be insulated from those direct effects because they have supplemental coverage. Nevertheless, some would see the effects in the form of higher premiums for supplemental policies. In addition, the option would make beneficiaries responsible for paying coinsurance on certain services—such as home health care—that are not currently subject to cost sharing. That requirement would increase administrative costs for some types of health care providers and could discourage enrollees from seeking cost-effective care in some cases.

RELATED OPTIONS: 570-16 and 570-17

570-16—Mandatory

Restrict Medigap Coverage of Medicare's Cost Sharing

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-2,100	-3,150	-3,290	-3,490	-3,740	-15,770	-39,260

Cost-sharing requirements in Medicare's fee-for-service sector can be substantial, so most beneficiaries obtain supplemental coverage from some source (including the Medicaid program or their former employer). About 30 percent of fee-for-service enrollees buy individual insurance—or medigap—policies that are designed to cover all or most of the cost sharing that Medicare requires. On average, medigap policyholders use at least 25 percent more services than Medicare beneficiaries who have no supplemental coverage and about 10 percent more services than beneficiaries who have supplemental coverage from a former employer (which tends to reduce but not eliminate their cost-sharing liabilities). Because beneficiaries are liable for only a portion of the costs of those additional services, it is taxpayers (through Medicare) and not medigap insurers or the policyholders themselves who bear most of the resulting costs.

Federal costs for Medicare could be reduced if medigap plans were restructured so that policyholders faced some cost sharing for Medicare services but still had a limit on their out-of-pocket costs. This option would bar medigap policies from paying any of the first $500 of an enrollee's cost-sharing liabilities for calendar year 2006 and would limit coverage to 50 percent of the next $4,000 in Medicare cost sharing. (All further cost sharing would be covered by the medigap policy, so enrollees could not pay more than $2,500 in cost sharing that year.) If those dollar limits were indexed to growth in average Medicare costs for later years, savings would total $2.1 billion in 2006 and $15.8 billion over five years. Those estimates assume that all current and future medigap policies will be required to meet the new standards. (Two similar designs for medigap policies were authorized by the Medicare Modernization Act of 2003, but enrollment in them will be optional.)

An argument in favor of this option is that most Medicare enrollees who had medigap policies would be better off financially as a result. Because insurers that offer medigap plans must compete against each other for business, they would most likely reduce premiums to reflect the lower costs of providing the new policies. Indeed, most medigap policyholders would have smaller annual expenses under this option because their medigap premiums would decline to a greater extent than their cost-sharing liabilities would increase. (Part of the reason is that premiums for medigap policies are generally somewhat higher than the average cost-sharing liabilities that the policies cover, because of the administrative and other costs that medigap insurers incur. But the primary reason is that most of those liabilities are generated by a minority of policyholders.) Greater exposure to Medicare's cost sharing could even lead some medigap policyholders to forgo treatments that would yield them few or no net health benefits. Indirectly, the decline in Medicare's costs would also cause that program's monthly premiums (which cover about 25 percent of costs for Medicare Part B) to fall, so other Medicare beneficiaries would also be better off.

An argument against this option is that Medigap policyholders would face more uncertainty about their out-of-pocket costs. For that reason, some policyholders might object to being barred from purchasing coverage for all of their cost sharing, even if they would be better off financially in most years under this option. (Most medigap policyholders buy optional coverage for the Part B deductible, while high-deductible medigap policies have attracted only limited enrollment despite their substantially lower premiums.) Moreover, in any given year, about a quarter of medigap policyholders would incur higher total costs under this option than they would under the current system, and those with costly chronic conditions might be worse off year after year. Finally, the decline in use of services by medigap policyholders (which would generate the federal savings under this option) might adversely affect their health in some cases.

RELATED OPTIONS: 570-15 and 570-17

570-17—Mandatory

Combine Changes to Medicare's Cost Sharing with Medigap Restrictions

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-7,120	-10,380	-10,690	-11,480	-12,490	-52,170	-131,480

The savings from redesigning Medicare's cost-sharing requirements (see option 570-15) could be increased by limiting medigap coverage at the same time (see option 570-16). That is, the savings that would result from instituting both changes simultaneously would exceed the sum of the savings derived from implementing each option in isolation. That synergy arises because medigap policyholders would not be insulated from the changes in Medicare's cost-sharing requirements if their medigap plans were also restructured.

Under this option, medigap plans would be prohibited from covering any of the new $500 combined deductible that would be required by Medicare in 2006 (described in option 570-15) and could cover only 50 percent of the program's remaining cost-sharing requirements. Such a medigap policy would correspond to the one described in option 570-16, with coverage limited to 50 percent of the next $4,000 in Medicare cost sharing (thus capping out-of-pocket expenses at $2,500 in 2006). Under this combined option, the point at which the medigap policy's cap on out-of-pocket costs was reached would also be the point at which the Medicare program's new cap was reached. Between the deductible and the catastrophic cap, policyholders would face a uniform coinsurance rate of 10 percent for all services. If those various dollar limits were indexed to growth in per capita costs for the Medicare program, this option would save $7.1 billion in 2006 and $52.2 billion over five years. Those estimates assume that participation in Medicare's new cost-sharing requirements will be mandatory and that all medigap policies will be required to follow the new standards.

An argument in favor of this option is that it would appreciably strengthen incentives for more prudent use of medical services by raising the initial threshold of health care costs that most Medicare beneficiaries faced and by ensuring that beneficiaries generally paid at least a portion of all subsequent costs (up to the out-of-pocket limit). As a result, the five-year savings from this option would be $2.1 billion more than the sum of savings achieved from options 570-15 and 570-16.

An argument against this option is that even with the new catastrophic cap, which would protect Medicare enrollees against substantial out-of-pocket expenses, some enrollees would object to any policy that denied them access to full supplemental coverage for their cost sharing. Furthermore, in any given year, a significant number of enrollees would see their combined payments for premiums and cost sharing rise as Medicare's average subsidies were reduced and medigap plans were restructured.

RELATED OPTIONS: 570-15 and 570-16

570-18—Mandatory

Reduce Medicare's Payments for Home Health Care

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-240	-680	-1,240	-1,900	-2,210	-6,270	-21,300

In 2004, Medicare paid about $11 billion for home health care services (which include skilled nursing care, physical and speech therapy, and home health-aide services for beneficiaries deemed to be homebound). Medicare spending on home health services grew rapidly in the late 1980s and early 1990s, when home health agencies were reimbursed separately for each home health visit, but it fell sharply after new payment systems were implemented under the Balanced Budget Act of 1997. Home health agencies currently receive a single payment from Medicare for providing all covered services to an individual beneficiary for a 60-day period (known as a home health episode). The Centers for Medicare and Medicaid Services sets the payment rates for different types of episodes prospectively, meaning that payment rates are set in advance to reflect the expected costs of each episode and are not determined by the costs that home health agencies actually incur. In calendar year 2005, payments per episode—ignoring geographic adjustments—will range from $1,192 to $6,366. Under current law, the base payment rate per episode is typically indexed to annual changes in input costs (such as wages for home health aides).

Among freestanding home health agencies, the aggregate Medicare margin—the excess of Medicare payments over providers' costs expressed as a percentage of payments—was high in 2001, at about 16 percent. (The aggregate Medicare margin was lower for hospital-based agencies, though still positive; the Medicare Payment Advisory Commission, or MedPAC, views the difference in margins as probably attributable to differences in accounting practices or in the efficiency of producing services.) Despite several modifications to the payment system for home health agencies in recent years, aggregate Medicare margins for freestanding agencies actually increased, to an estimated 17 percent in 2004. The continuing high margins appear to be the result of reductions in home health agencies' costs in response to the incentives created by the new prospective payment system.

This option would freeze the base payment for each home health episode at its calendar year 2005 level ($2,264) through 2009, with the goal of gradually narrowing the gap between payments and costs. The change proposed in this option would reduce federal outlays by $240 million in 2006 and by $6.3 billion over five years. A rationale for this option is that if average per-episode costs for home health agencies grew at the rate of inflation, the freeze in the base payment would still leave average payments at least 10 percent above agencies' average costs for 2009 and beyond. That difference would provide a margin for agencies that have slightly higher than average costs or that experience faster cost growth.

A drawback of this option is that it could reduce access to home health services for Medicare beneficiaries. Home health agencies that had substantially higher costs than average and that were not able to reduce their operating expenses sufficiently would cease participating in the program. As a result, some beneficiaries might have difficulty obtaining home health services. Also, although MedPAC has not thus far identified quality problems under the new payment system, lower payment rates could lead home health agencies to reduce the level or quality of the services they provide.

RELATED OPTIONS: 570-19 and 570-20

570-19—Mandatory

Impose a Copayment Requirement on Home Health Episodes Covered by Medicare

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1,470	-2,260	-2,470	-2,680	-2,930	-11,800	-31,480

Medicare's spending for home health care dropped during the late 1990s following passage of the Balanced Budget Act of 1997, which introduced a prospective payment system (PPS) for home health services. But the Congressional Budget Office projects that the use of home health services, and the resulting costs to the Medicare program, will grow rapidly over the next 10 years. One reason for the projected rapid growth is that Medicare beneficiaries are not currently required to pay any of the cost of home health services covered by the program.

This option would charge beneficiaries a copayment amounting to 10 percent of the total cost of each home health "episode"—a 60-day period of services—covered by Medicare, starting on January 1, 2006. That change would yield net federal savings of $1.5 billion in 2006 and $11.8 billion over five years.

An argument in favor of this option is that it would directly offset a portion of Medicare's home health outlays and encourage beneficiaries to be cost-conscious in their use of home health services. The use of services would also decrease, most likely among the approximately 14 percent of beneficiaries with fee-for-service Medicare only (those who are not enrolled in Medicaid or a health maintenance organization, or who have supplemental insurance, such as medigap or "wraparound" retiree coverage).

An argument against this option is that it would increase the risk of significant out-of-pocket costs for the 14 percent of Medicare enrollees with only fee-for-service coverage and would probably reduce their use of services. Those enrollees tend to have lower income than do beneficiaries with private supplemental insurance. (Among the majority of enrollees who have supplemental insurance, little or no drop in use would be expected, assuming their supplemental policies were expanded to cover the home health copayment proposed in this option.) Also, the 27 percent of enrollees with individually purchased medigap policies would probably face higher premiums, and the costs of employer-sponsored medigap policies and the Medicaid program could also rise (again assuming that supplemental policies covered the proposed home-health copayment). Finally, this option would result in increased Medicaid outlays for home health care. (The federal share of increased Medicaid outlays is included in the estimated change in outlays.)

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RELATED OPTIONS: 570-18 and 570-20

570-20—Mandatory

Impose Cost Sharing for the First 20 Days of a Skilled Nursing Facility Stay Under Medicare

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1,060	-1,580	-1,680	-1,790	-1,880	-7,990	-19,190

For enrollees who have been hospitalized and need continuing skilled nursing care or rehabilitative services on a daily basis, Medicare currently covers up to 100 days of care in a skilled nursing facility (SNF). The average SNF stay covered by Medicare lasts about 20 days, and more than half of Medicare's SNF payments are for the first 20 days of such a stay. The first 20 days of SNF care are free to the beneficiary, but the next 80 days require a copayment that is projected to be $118 per day in 2006. That copayment is set at one-eighth of Medicare's deductible for each hospital inpatient "spell," and thus the copayment grows over time along with increases in average daily hospital costs. Total payments to SNFs under Part A of Medicare are projected to average about $375 per day in 2006, so the $118 copayment corresponds to an average coinsurance rate of more than 30 percent. The Congressional Budget Office projects that total Medicare spending for SNF services provided under Part A will rise from $17.6 billion in 2006 to $26.3 billion in 2015.

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This option would impose a copayment for the first 20 days of care in a skilled nursing facility equal to 5 percent of the inpatient deductible, which would be $47.20 per day in 2006. The maximum additional liability for a beneficiary would thus equal the inpatient deductible (projected by CBO to be $944 in 2006) and would rise at the same rate over time. CBO estimates that imposing this copayment will reduce federal outlays by $1.1 billion in 2006 and by $8.0 billion over five years.

The effect of this option on the use of SNF services and beneficiaries' out-of-pocket payments would depend on whether participants had supplemental coverage for their Medicare cost sharing. Most individual medigap policies include full coverage of current SNF copayments, so beneficiaries with such policies would be insulated from the direct impact of the higher copayments but could expect to see the additional costs reflected in their medigap premiums. This option would not affect Medicare beneficiaries who received full Medicaid benefits or those considered Qualified Medicare Beneficiaries, because their Medicare cost sharing would be paid by Medicaid. CBO's cost estimate reflects the additional federal Medicaid spending that will occur under the option as a result. (State Medicaid programs will also pay correspondingly more.)

Overall, 2 percent to 3 percent of all Medicare beneficiaries would incur higher out-of-pocket costs under this option in any given year, CBO estimates. For those beneficiaries, the lack of cost sharing for the first 20 days of SNF care under current law probably encourages additional use of those services. An advantage of imposing a copayment, therefore, would be that those beneficiaries would have to balance the costs and benefits of receiving care in a skilled nursing facility.

One argument against this option is that enrollees who use SNF care would already have been liable for the inpatient deductible as a result of their initial hospital admission. The added copayment could lead some beneficiaries to forgo services that would help avoid further complications from surgery or improve their health in other ways. Some beneficiaries might choose instead to receive similar services as a home health care benefit, which currently has no cost sharing. (The resulting added payments for home health services are reflected in CBO's estimate of net program savings for this option.)

RELATED OPTION: 570-19

570-21—Mandatory

Impose A Deductible and Coinsurance Amounts for Clinical Laboratory Services Under Medicare

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-800	-1,200	-1,200	-1,300	-1,400	-5,900	-14,500

Medicare currently pays 100 percent of approved fees for laboratory services provided to enrollees. Medicare's payment is set by a fee schedule, and providers must accept that fee as full payment for the service. For most other services provided under Medicare's Supplementary Medical Insurance (SMI) program, beneficiaries are subject to both a $100 deductible and a coinsurance rate of 20 percent.

This option would impose the SMI program's usual deductible and coinsurance requirements on laboratory services, beginning January 1, 2006. The change would yield federal savings of $800 million in 2006 and $5.9 billion over five years.

A rationale for this option is that, besides reducing costs to Medicare, such a change would make cost-sharing requirements under the SMI program more uniform and therefore easier to understand. Moreover, although decisions about the appropriateness of tests are generally left to physicians (whose judgments do not appear to depend on enrollees' cost-sharing liabilities), some enrollees might be less likely to request or undergo laboratory tests of little expected benefit if they had to pay part of the costs themselves.

An argument against this option is that only a small portion of the expected savings would stem from more prudent use of laboratory services; the rest would reflect the transfer to enrollees of costs now borne by Medicare. Moreover, the billing costs of some providers, such as independent laboratories, would be higher under this option because those providers would have to bill both Medicare and enrollees to collect their full fees. (Currently, they have no need to bill enrollees directly for clinical laboratory services.)